



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name

Zurich American Insurance Co

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2152-01

MFDR Date Received

February 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid in accordance with DWC Rule 134.403."

Amount in Dispute: \$954.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We will supplement a response once review has been completed."

Response Submitted by: Gallagher Bassett Services, Inc. 6504 International Parkway, Plano, TX 75093

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2011	Outpatient Hospital Services	\$954.20	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 29, 2011

- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

Explanation Of Benefits Dated December 22, 2011

- 97 (97) THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR

ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

- 21 (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- BL THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. These services are classified under APC 0272, which, per OPPS Addendum A, has a payment rate of \$83.50. This amount multiplied by 60% yields an unadjusted labor-related amount of \$50.10. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of \$48.35. The non-labor related portion is 40% of the APC rate or \$33.40. The sum of the labor and non-labor related amounts is \$81.75. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$81.75. This amount multiplied by 200% yields a MAR of \$163.50.
 - Procedure code 62368 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0691, which, per OPPS Addendum A, has a payment rate of \$166.82. This amount multiplied by 60% yields an unadjusted labor-related amount of \$100.09. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of \$96.59. The non-labor related portion is 40% of the APC rate or \$66.73. The sum of the labor and non-labor related amounts is \$163.32. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$163.32. This amount multiplied by 200% yields a MAR of \$326.64.
 - Procedure code 95991 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0439, which, per OPPS Addendum A, has a payment rate of \$128.44. This amount multiplied by 60% yields an unadjusted labor-related amount of \$77.06. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of \$74.36. The non-labor related portion is 40% of the APC rate or \$51.38. The sum of the labor and non-labor related amounts is \$125.74. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$125.74. This amount multiplied by 200% yields a MAR of \$251.48.

3. The total allowable reimbursement for the services in dispute is \$741.62. This amount less the amount previously paid by the insurance carrier of \$741.61 leaves an amount due to the requestor of \$0.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	May 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.